ABSTRACT

SOCIAL WORK

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THE EFFECTS OF A POSITIVE
REINFORCEMENT PROGRAM ON A STROKE PATIENT 'S
PERSONAL GROOMING SKILLS

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This study examined the effects of a positive reinforcement program on a stroke patient's increased involvement with personal grooming skills of eight weeks and a follow up report of twelve weeks. The results showed that the patient was able to perform three of the five tasks during the twenty weeks. A rating sheet was used to measure the performance of five tasks: bathing, combing his hair, brushing his teeth, shaving, and changing his clothes. Two questionnaires were given to the nursing staff and family members to evaluate the patient's progress. The family members evaluation of the patient's progress was excellent. The nursing staff evaluation stated that the patient's progress had improved.

ACKNOWLEDGMENT

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THE EFFECTS OF A POSITIVE REINFORCEMENT PROGRAM ON A STROKE PATIENT'S PERSONAL GROOMING SKILLS

A THESIS

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INTRODUCTION

Each year, thousands of people incur traumatic injuries or illness that disrupt or destroy their manner of living. It is not the severity of the injury alone that determines the psychological response of the victim. Rather, it is the person, his environment (meaning the social, physical and biological environment) that determines behavior.

A stroke is medically called a cerebrovascular accident. Persons with a stroke are often misunderstood, neglected, ridiculed, unwanted and abused.[1] Patients with stroke's are especially prone to complications that may cause more problems and disability than the stroke itself. Severe disability may produce drastic changes and many patients may develop alternate ways to carry out daily activities and functions.[2]

Family members, themselves severely affected by the patient's sudden disability, frequently review the past and leap to the future. Feelings of nurturance and support for the love one, and a wish to relieve the pain of the present, are especially conducive to fantasies of a happier future for the relatives or their disabled love one.

People who live alone and obviously to their loved ones

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[1]Pamela W. Duncan, Stroke Rehabilitation: The Recovery of Motor Control. (Chicago: Year Book Medical Publication, 1987), p. 3.

[2]Louis R. Caplan, "Prevention and Risk Factors" Stroke a Clinical Approach ,(Stoneham. MA.: Butterworths, 1986), p. 295.

can no longer be considered safe to continue this arrangement after suffering a stroke. Those who are ambulatory and have long been use to independence often fight vigorously to maintain their accustomed household.[3]

The ultimate goal, however possible, is for the patient to return to their community with newly acquired activities of daily living skills. When there are skills the patient cannot perform independently, family members or significant others should be instructed in how to assist the patient properly and safely in the particular activity that requires assistance. Failure to obtain independence in self-care will foster dependency on family members or significant others.[4]

Statement of The Problem

Strokes are the most common life-threatening neurologic disease and is the third leading cause of death in the United States after heart disease and cancer. Although strokes are more disabling than lethal, 169,500 deaths were attributed to cerebrovascular disease. The American Heart Association estimates there will be approximately 500,000 new victims of strokes each year with 1,830,000 survivors in the United States. The rate of decline has been rather constant of 1 percent per year through a number of revisions of the 9th

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[3]Daniel B. Heir, "Recovery from Behavioral Deficits after Stroke", Stroke Rehabilitation. (Butterworths, 1979), p. 146-147.

[4]Helen Broida, Coping with Stroke (California: College Hill Press, 1979), p. 112-113.

edition of the International Classification of Disease (ICD).[5]

It is important to distinguish between the direct and indirect effects of a stroke. Any patient might be expected to suffer some mood changes and behavior problems following a sudden and unexpected change in their level of function. Some patients seem to be predisposed to develop more prolonged levels of disability following a stroke and social factors are important.

For many patients their lives are greatly changed by the effects of a stroke. The physical and psychological effects of the stroke can cause a great strain on marital relationships, children may be unwilling to take on responsibility for an elderly patient, or the patient may be abandoned by his/her family. The patient may attempt to deny the limitations imposed by the stroke. Unrealistic attempts to become independent or to regain employment may create great anger and frustration. Conversely, the patient may become excessively dependent, so that invalidism creates a considerable burden. The patient may use helplessness and suffering to manipulate the family by creating feelings of guilt and sympathy. Many patients are unable to cope with the major changes that result from a stroke.[6]

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[5]Phillip A Wolf, "Epidemiology of Strokes in North American" Stroke: Pathophysiology Diagnosis and Management.(New York: Churchill Livingstone, 1986). p. 19.

[6]Barbara A. Lilliston. "Psychosocial Responses to Trauma Physical Disability". Social Work in Health Care. vol. 10. no.4 (Summer) 1985.

Chapter II

REVIEW OF LITERATURE

Stroke and cerebral trauma are all synonymous with brain damage. These terms imply that an individual has had a normally functioning brain, consistent with his age, which was acutely damage. Such damage will almost always result in behavioral deficits which may include decreases in physical abilities, intellectual performance, social functioning, emotional control, or any combination of the four. Even very mild injuries, which may not give observable evidence of damage, can show up as behavioral deficits later.[1]

The problems faced by the newly disabled person are those of coping with physical and psychological loss, changes in body image, social status, and earning capacity, the anxiety and grief which often accompany these changes and the need to learn new behaviors and make concrete plans for an uncertain future. Each individual will seek personal solution to these problems and thus define their own adjustment to their disability.[2]

One of the most devastating effects of a visible physical disability is a change in social status of the individual.

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[1]Neath W. Folger. "Epidemiology of Cerebrovascular Disease". Stroke Rehabilitation. (Los Angeles: Williams and Wilkins, 1987). p. 64-66.

[2]Gary T. Athelstan. "Psychology Adjustments to Chronic Disease and Disability". Handbook of Severe Disability. Washington DC: U.S. Government Printing Office. p. 15.

Disabled persons in society assume a special kind of minority status and occupy a socially devalued role. Visibly disabled persons are often assumed by others to be less attractive, less desirable, and less capable in ways which are totally unrelated to their disability.[3]

A loss of social status may also result from the indirect effects of disability, such as economics consequences. The cost of acute and long-term medical care for chronic disease or disability maybe so great as to deplete all of a family's assets. Usually when any member of the family is disabled by a stroke will result in a reduction of the family's total income.[4]

Considering the many negative effects of disability, it is only natural that the onset of a major disability will often be accompanied by significant emotional reactions.
In the first phase, patients experience shock during the first few hours or days after the onset of disability. The patient usually feel and react minimally and may have little awareness of what has happen. Realization is the second phase in which some recognition of the reality and seriousness of the disability begins to develop. Anxiety, possibly even panic, maybe the predominant emotional reaction. The fear is based

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[3]Janet Carr and Roberta B. Shepherd. A Motor Relearning Program for Stroke. (London: William Heinemann Medical Books, 1987). p. 25-27.

[4]Gary, loc. cit., p.15.

on anticipation of possible death, critical losses or unpredictable change. During the third phase anxiety normally follows the onset of disability can be easily overwhelming for the individual if there are no defense mechanisms available to help the patient cope with the situation. Predominate among these defenses is denial. The individual defends against the threat of disability by denying its existence or seriousness.[5] The fourth phase is acknowledgement which the individual achieves an accurate understanding of the nature of the disability and the imposed limitations. Some people may demonstrate a very thorough intellectual understanding of the disability prior to this time, but still not display full appreciation of its implication. Acknowledgement is usually marked by the onset of some degree of depression. The depression which often accompanies recognition of the reality and seriousness of the disability is a very natural grief reaction to the losses that result. Adaptation is the final phase of adjustment to disability. The term means simply that the individual has worked through any major emotional reactions to the disability, is realistic about their limitations and is psychologically ready to make use of their potential. This is sometimes referred to as the "acceptance" phase.[6] But it should be noted that accepting a disability does not imply a willingness to accept a diminished life or to

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[5]Gary, loc. cit., p. 16.

[6]Gary, loc. cit., p. 16.

be happy about being disabled. Rather, acceptance or adaptation means learning to live with certain limitations and to make the best use of remaining assets.

Data on the level of performance with stroke patients suggest that more than 60 percent and as many as 90 percent of all patients, including the most severely damaged, will walk, dress themselves independently, feed themselves and have bladder and bowel control.[7] Patients with strokes affecting the cerebrum usually have one or the other side affected (unless, of course, they had more than one stroke). The different sides are called Left Cerebral Damage and Right Cerebral Damage. Depending on which side the trauma has occurred will effect the individuals deficits and behavior.

People who have left cerebral damage, typically the most visible sign will be paralysis of the right side of the body (right hemiplegia). When confronted with a new problem, persons with damage to the left cerebral hemisphere tend to respond in a slow, scattered, disorganized, anxious fashion, regardless of whether the problem is presented verbally or by demonstration. As the person becomes familiar with the new problems and begins to handle it, anxiety disappears. Because right hemiplegic tend to be very cautious and anxious about performing any new task, they are likely to need reassurance and frequent indications that they are performing correctly.

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[7]Henry, Barnett. Stroke: Pathophysiology Diagnosis and Management. (New York: Churchill Livington, 1986). p. 3-4.

Smiles, nods, or pats on the back after a successful completion of each step of a task will reassure the person and encourage the individual to proceed to the next step.[8]

People who have right cerebral damage, typically the most visible sign will be paralysis of the left side of the body (left hemiplegia). The primary deficit of the right side is the inability to accurately interpret visual information and properly orient oneself with respect to the environment. These deficits may cause the individual to be mislabeled by disappointed observers as uncooperative, unmotivated, overly dependent or confused when they unexpectedly encounters difficulties with what appears to be simple daily routine activities. Individuals with severe visual deficits have more difficulty learning how to care for themselves than individuals with speech deficits.[9]

Much of the research studies conducted using positive reinforcement has indicated that a reinforcer is defined by its effects on behavior.

Social reinforcers such as verbal praise, attention, physical contact (including affectionate or approving touches, contact, nods of approval, and winks) are conditioned reinforcers. They are easily administered and a verbal statement or smile can be given quickly. Providing praise takes little time so there is no delay in praising a number of

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[8]Ibid., p. 5.

[9]Ibid., p. 6-7.

individuals almost immediately. In short, a desirable feature of using social reinforcement is that there is an increased likelihood that behaviors will be maintain outside of the specific training setting.[10]

Social reinforcement has been used extensively in various settings where praise is delivered to study behaviors.

Kirby and Shields used praise to alter the behavior of a 13 year old boy in a seventh-grade classroom. The boy was doing poorly on his class assignments particularly arithmetic. Also, he rarely paid attention to the lesson and constantly had to be reminded to work. Praise was used to improve performance on arithmetic assignments. The results of the praises increased correct answers in arithmetic. Studies have shown that reinforcing academic performance not only improves the specific behaviors focused upon but also increases classroom attentions and reduces disrupted behavior.[11]

A young retarded woman trained in a Good Will Industry was having difficulty adjusting. The supervisor was ready to evict her from the setting. The counselor found the woman rate of completing her tasks were low compared to other trainees in the setting. The counselor noticed that the client tended to annoy male trainees more than female

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[10]Vimala Pillari. Human Behavior in the Social Environment.(California: Brooks/Cales Company, 1988). p. 168.

[11]Alan E. Kazdin, Behavioral Modification in Applied Settings (Homewood, Ill: The Dorsey Press, 1980), p. 134.

trainees. The counselor arranged for the staff person in charge (a male and female) to have just the male respond to the client to do task-appropriate behaviors. In the next two weeks, using just this intervention the clients output was an average of 80 tasks per week.[12]

Pendarivs and Grinnell conducted a study to test the effectiveness of a multidisciplinary-team approach to the rehabilitation of stroke patients with their activities of daily living (ADL). Twenty-six patients were referred to a rehabilitation team during a 7-month period and were compared to 32 stroke patients not referred. Professionals on the team included a physical therapist, an occupational therapist, a pharmacist, dietician and a social worker. Analysis of a 3-item functional health measure completed by both groups of patients 3 months after leaving the hospital. The three items were combing their hair, changing clothes and walking. After 3 months the hospital indicated higher scores for patients who had been in the team rehabilitation program.[13]

Schmidt and Herman conducted a study on the status of stroke patients in a community assessment program. The program was to assess norms relating to stroke patients, the typical stroke patient's were female aged 71, with right hemiplegia,

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[12]Martin Bloom and Joel Fischer, Evaluating Practice: Guidelines for the Accountable Profession. (New Jersey: Prentice-Hall, 1982), p. 302.

[13]John F. Pendarvis and Richard M. Grinnell. "The Use of a Rehabilitation Team for Stroke Patients". Social work in Health Care. vol 6. no. 2. (Winter). p. 77.

who returned home, living with another adult, after spending 17.5 days in an acute care hospital. Behavior functional levels of 105 disabled stroke patients were assessed, using a scale to measure activities of daily living, home activities, outside activities and social interaction. Findings revealed stroke patients generally function higher in activities of daily living than in social interactions. Stroke patients living with another adult scored lower in activities of daily living than those living alone, but functioned better in social interactions.[14]

Zippel and Conradi compared the rehabilitation of 2 groups of geriatric stroke patients. First group consist of 101 elderly patients and the second group consist of 295 elderly patients. Group 1, participated in a conventional rehabilitation program from 1978-1981; and Group 2, participated in a more modern program form 1983-1986, which used stimuli such as games, music and psychosocial exercises. The degree of importance in carrying out daily activities and walking were measured and resulting in group 2 having a higher scores. [15]

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[14]Susan Schmidt and Lynn M. Herman. "Status of Stroke Patients: A Community Assessment". Archives of Physical Medicine and Rehabilitation. vol. 67. no. 2. (February) 1986. p.99-102.

[15]C Zipple and M. Conradi. "The conceptional basis of the Rehabilitation in Patients with Stroke." Zeitschrift Gerontologie. vol. 21. no. 6. 1988. pp. 334-338.

Overview of Theoretical Orientation

The conceptual framework upon which the present study is built is applied behavior largely derived from the works of B. F. Skinner.

The behavioral approach departs from the traditional conception of behavior by rejecting inferred motives, hypothesized needs, impulses, and drives which supposedly explain behavior. Rather, emphasis is placed upon environmental, situational, and social determinants that influence behavior. The behavior approach considers the majority of behaviors learned or alterable through procedures.[16] Behavioral modification attempts to provide special learning experiences to develop appropriate and adaptive behavior. According to Skinner, behaviors amenable to control by altering consequences which follow them are referred to as operantes because they are responses which operate (have some influences) on the environment and generate consequences. Operantes are strengthened (increased) weakened (decreased) as a function of the events which follow them. Most behaviors which are performed in everyday life are operantes.[17]

The behavioral approach toward assessment focus on the behaviors that are to be altered rather than on the underlying

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[16]Alan E. Kazdin, Behavioral Modification in Applied Settings (Homewood, Ill: The Dorsey Press, 1980) p. 12.

[17]Ibid., p. 18.

personality considered to cause behavior. Although a problem may be described in vague and general terms, the behavior modifier seeks to clarify these terms by observing the behavior that requires change and the events which proceed and follow the behavior.[18]

The effectiveness of reinforcement depends upon several factors. These include the delay between performance of a response and the schedule of reinforcement. Responses which occur in close proximity of reinforcement are learned better than responses remote from reinforcement. A reinforcer should be delivered immediately after the target response to maximize the effect of reinforcement. The amount of reinforcement delivered for a response also determines the extent to which a response will be performed. The greater the amount of a reinforcer delivered for a response, the more frequent the response.[19]

Treatment in applied settings where operant conditioning techniques are extensively implemented, emphasis is placed upon external events in the environment that can be used to alter behavior. In most applied intervention programs, emphasis is placed on overt behavior and on external situational determinants that can be altered to influence

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[18]Ibid., p. 20.

[19]Ibid., p. 124.

these behaviors.[20]

Purpose of the Study

This study examined the effects of a positive reinforcement program of a stroke patient's involvement with personal grooming behavior.

Due to the poor performance of the patient's personal grooming behavior a program was developed to reflect the needs of the patient and family members.

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[20]Ibid., p. 21.

Chapter III

Methodology

Setting

This study was conducted at the Veterans Affairs Medical Center located in Decatur, Georgia. The Atlanta Veterans Affairs Medical Center is a 500 authorized bed facility primary, secondary and tertiary care medical center, which provides acute, surgical, intermediate and psychiatric care. The Intermediate Care Unit is a recover unit for patients from other units within the center. On this unit the patients continue their hospital treatment plans in Occupational Therapy, Physical Therapy, Radiation treatment and various other treatments. The patient and family members engage in their discharge plans with the assistance of the social worker and the interdisciplinary team.

Background Information of the Case

Mr. J., is a 70 year old, divorced caucasian male. Mr. J. had a stroke in 1989, leaving him with a moderate degree of dysfunction on his left side (right hemiplegia). He lives alone in a senior citizen highrise apartment. On October 5, 1991, he was admitted to the Veterans Affairs Medical Center for dehydration. The patient fell about 4 a.m. while going to the bathroom and remained on the floor for 12 hours. One of his neighbors heard him yelling for help and called the apartment manager. The manager called Mr. J. son Kenneth and he brought him to the hospital.

Based on the initial interview the patient appears competent and his level of functioning was fair. Although the patient has severe neurological deficits which have adversely effected some of his motor skills (i.e. ambulation, and ability to perform domestic task and activities in daily living skills); he was oriented and cognitively intact. He was in denial about his addiction of alcohol and refuses to commit to achieving and maintain sobriety. He acknowledged that he experiences difficulty with living independently because of his neurological deficits and requires the assistance of his family to live independently. The patient was taking Occupational Therapy, Physical Therapy and he was referred to the Psychiatry and Podiatry Service for evaluation.

The patient has a supportive family and his family members consist of his ex-wife, his son, stepdaughter and stepson. According to his ex-wife, the patient would not take care of himself and family members have been assuming responsibilities for him. The patient would not clean his apartment or take care of his personal grooming. Family members expressed a desire to help Mr. J. improve his grooming behavior. His ex-wife also stated that the patient has had a 15 year history of alcohol abuse and is a heavy smoker.

Treatment Hypothesis

A positive reinforcement program will increase performance on a stroke patient's personal grooming skills.

Intervention Strategy

The intervention program used consisted of positive reinforcement with Mr. J. grooming behavior.

With Mr. J's personal grooming skills five area's were target: bathing, combing his hair, brushing his teeth, shaving and changing his clothes. The social worker modeled each area to be performed by Mr. J. In demonstrating how individual's hair is considered combed completely and neatly Mr. J was able to participate. The worker showed the patient how to brush his teeth, shave his entire face and explained changing his clothes included upper and lower external and upper and lower internal. Mr. J. agreed to perform these tasks every morning between 7 a. m. and 8 a. m. Mr. J's grooming skills were explained to the nursing staff and to his family.

The social worker greeted the patient every morning and he was praised for performing three tasks. The nursing staff praised the patient for performing two or three tasks and family members praised Mr. J. for performing three of his grooming skills. Whenever the patient performed one or two task, the worker would express the importance of completing three or more tasks.

Instrument

This rating form was used to monitor the performance of the patients' grooming skills and indicate five task: bathing - washing the entire body completely with or without assistance; combing his hair - combing the entire head completely and neatly; brushing his teeth - using a toothbrush with toothpaste, gel or powder; shaving - using a electric shaver or shaving gels or powders, and a razor to remove hair from his face and changing his clothes - upper and lower body, underclothes putting them on and taking them off with or without assistance. These tasks were performed every morning. See appendix A for a copy of the rating sheet.

Two questionnaires were used to evaluate the patient's progress, one for the family members and one for the nursing staff. Both questionnaires consist of five questions. These questionnaires were administered to the family members and the nursing staff at the end of the twenty week period. See appendices B and C for copies of the questionnaires.

Research Design

The A-B Design was used in this study because of the basic distinction between, and the combing of, a baseline observation period A, and a intervention period B.

This study measured the effects of a eight week positive reinforcement program on a stroke patient's personal grooming skills. A rating sheet was used to monitor the patient's progress by the social worker, nursing staff and family members. The rating sheet was used daily, Monday through Sunday between 7 a.m. and 8 a. m.

After eight weeks the patient was transferred to the nursing home unit and was monitored for twelve weeks using the same rating sheet. The purpose of this study was to ascertain if this intervention had a specific effect on the patient's potential to perform the grooming tasks.

Chapter IV

PRESENTATION OF RESULTS

The results of this study are presented in two sections.

Figure 1, depicts the progress of the number of tasks performed by the patient. During the baseline period Mr. J. was performing one task of combing his hair. The patient appeared to have little motivation in performing his personal grooming skills. The patient's intervention process lasted 42 days. As can be seen in Figure 1, the patient was able to perform three of the five task and occasionally performed four or five tasks during the intervention process. Mr. J was able to comb his hair, brush his teeth and change his clothes daily. Mr. J. was transferred to the nursing home unit; however Mr. J. was able to maintain performing the same three tasks during the follow up period as can be seen in Figure 1.

The visual pattern of Figure 1 is significant, and the difference between the baseline and intervention phase indicates a positive change in Mr. J's grooming behavior. The specific days on which this patient's tasks dropped the most dealt with Mr. J's feeling ill. This graph also supports the treatment hypothesis.

Table 1, presents the evaluation of the patient's grooming skills by family members. This questionnaire was given to four family members to evaluate the progress of Mr. J. The questions consist of how the patient's grooming skills were before hospitalization compared to an overall

FIGURE 1 NUMBER OF TASK PERFORMED ON PERSONAL GROOMING SKILLS.

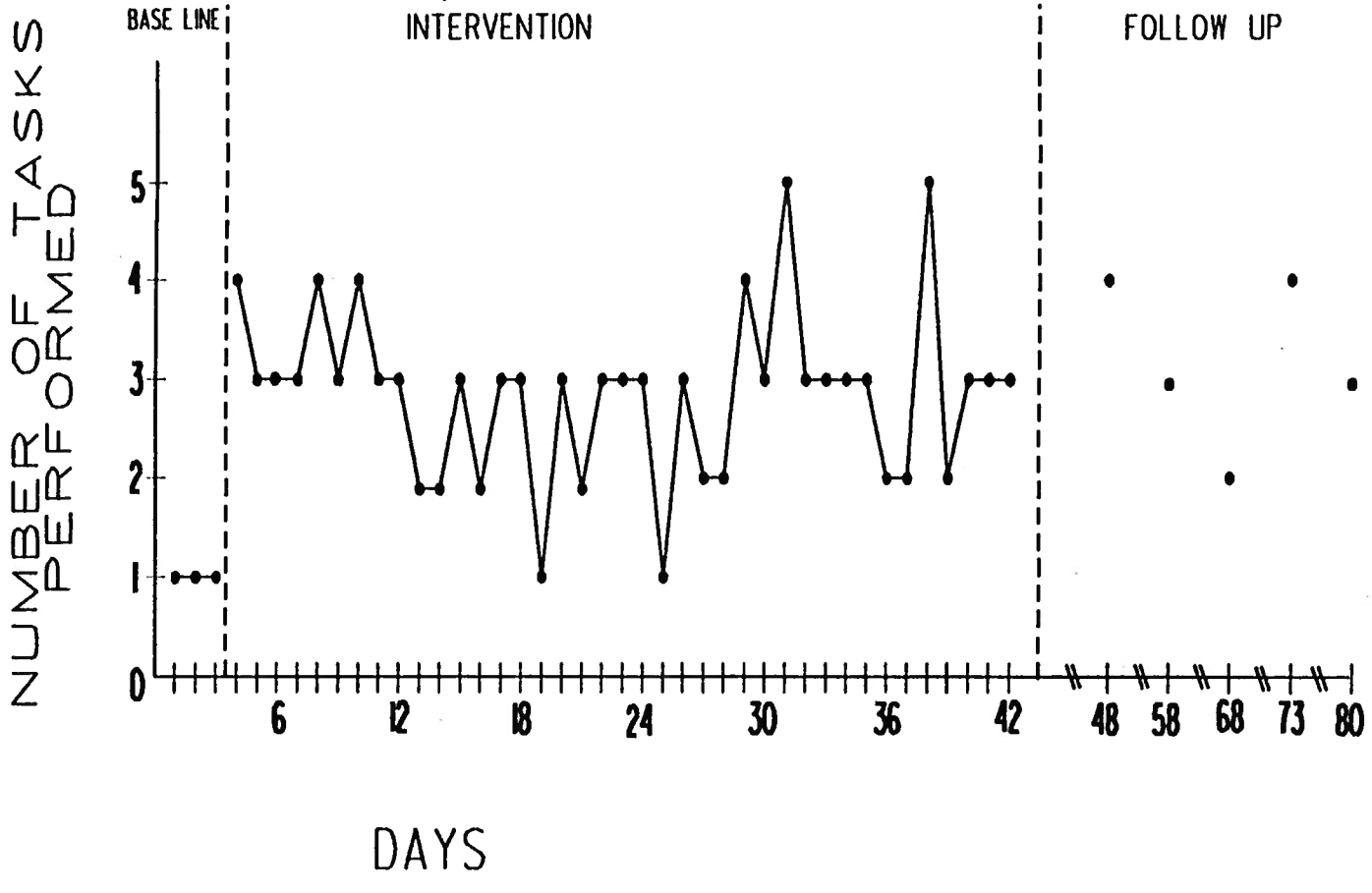

TABLE 1

Evaluation of Patient's Grooming Skills by Family Members

1. How would you describe Mr. J personal grooming before entering the hospital?	Excellent	Good	Fair	Poor 100%
2. After three weeks how was Mr. J grooming skills?	Excellent 50%	Good 50%	Fair	Poor
3. How would you rate the quality of service Mr. J. received from social services?	Excellent 100%	Good	Fair	Poor
4. Have the social services you received helped you to deal more effectively with your problems?	Yes, they helped a a great 100%	Yes, they helped somewhat	No, they really didn't help	No, they seem to make things worst
5. In an overall, general how satisfied are with the social services you have received?	Very satisfied 100%	Mostly satisfied	Indifferent or mildly dissatisfied	Quite dis satisfied

improvement. The response from the family members was excellent.

Table 2, presents the evaluation of the patient's grooming skills by nursing staff. The questionnaire was given to six nurses to evaluate the progress of Mr. J. The questions consist of how the patient's grooming skills were two weeks after admission compared to the overall performance of the patient's grooming skills. The nurses response was that the patient's progress had improved.

TABLE 2

EVALUATION OF PATIENT'S GROOMING SKILLS BY NURSING STAFF

1. How would you describe Mr. J personal grooming skills two weeks after admission?	Excellent 50%	Good 50%	Fair	Poor
2. Did Mr. J perform his personal grooming skills without being advised?	Never	Sometimes 50%	Most 50%	Always
3. Did Mr. J personal grooming skills improve during his hospitalization?	Yes, a great 80%	Yes, somewhat 20%	No	Seemed to to get worst
4. How would you rate the quality of service Mr. J received from social services?	Excellent 100%	Good	Fair	Poor
5. In an overall, general sense did Mr. J personal grooming skills improve?	No, definitely	No, I don't think so	Yes, I think so 70%	Yes definitely 30%

Chapter V

SUMMARY AND CONCLUSION

Each individual stroke survivor will eventually reach the point where his or her long term potential for various types of functions can be assessed.

Mr. J was able to perform three task during the twenty weeks. On several occasions Mr. J would look for the social worker to receive praises for performing his grooming skills. Family members and the nursing staff experienced the same response from Mr. J.

Mr. J. was unable to bathe himself everyday because baths were scheduled by the hospital, but the patient was able to bathe with the assistance from the nursing staff. The patient did not need to shave everyday. The patient was able to perform these tasks without being advised; however the patient did perform four or five task occasionally. After the intervention program was completed the patient was able to continue to perform three of the five tasks during the follow up study.

Limitation of the study

The stroke patient in a hospital setting is limited to the number of therapeutic treatments that can be administered and this is difficult for the social worker to evaluate the patients needs of additional therapeutic treatment after the patient has been discharged. Family members and nursing staff recorded the rating sheets which made it difficult to know if

the recorded information was accurate. Future studies should include replications by other researchers as well as comparisons with other treatment and component analyses. Social workers should find the results presented here encouraging enough to seriously consider incorporating this treatment into their repertoire of intervention skills.

Suggested Research Directions

More research needs to be conducted on the stroke patient's psychosocial aspects. Most of the data relating to the stroke patients focused upon the medical findings and implications of stroke. Some studies have been done concerning the effects of the stroke on the patient regarding which side of the body is effected. The relationship between the patient coping mechanisms, their families support and patients new environment. This correlation should be examined as to the cause and effects it will have on the stroke patient.

This has been the first attempt of a positive reinforcement program dealing with the patient's psychosocial environment. More research needs to be continued with other stroke patients to test the effectiveness of the program.

Chapter VI

IMPLICATIONS FOR SOCIAL WORK PRACTICE

Realizing that not all people react to an event in the same manner requires one to individualize each assessment of responses. Such assessment needs to consider the individual's psychological development, style of coping and style of learning new material. One needs to consider the nature of family involvement and their capacity to be supportive.

Interventions must take into consideration the affective responses of the patient and the preferred patterns for coping used by the family. When discussing the patient's discharge plans the social worker must realize that only about 10 percent of people who survive strokes can return to their accustomed life-styles with virtually no residual impairment.

The stroke patient will require special services such as physical therapy, occupational therapy, speech and language therapy, and rehabilitation therapy. The social worker should to become knowledgeable about the resources that are available to the patient and their family.

An interesting finding in this study was that a stroke patient was able to benefit from a positive reinforcement program with his grooming skills. This was demonstrated with the evaluation from his family and from the nursing staff.

Relevance to the Agency

Professional social workers should base their practice on careful evaluation of outcome with each an every client and

carefully select practice methods and treatment techniques according to the results of research findings. The worker used concrete, observable, and measurable terms to describe the problem, intervention, goals and outcomes of a particular situation.

This agency should consider incorporating tools for evaluating objectively the effectiveness of each client, group or system on the target problem over the entire course of intervention. The worker should consider to provide a continuous record of changes in the target problem that can be a model for demonstrating accountability for the agency.

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APPENDICES

APPENDIX A

DAILY LIVING SKILLS

	MON.	TUES.	WED.	THUR.	FRI.	SAT.	SUN.
BATHING							
SHAVING							
BRUSHING TEETH							
COMBING HAIR							
CHANGING CLOTHES							

Note: Please check appropriate box daily.

Date:_____

Name:_____

Time:_____

APPENDIX B

QUESTIONNAIRE FOR FAMILY

1. How would you describe Mr. J personal grooming skills before entering the hospital?

4	3	2	1
excellent	good	fair	poor

2. After three weeks how was Mr. J's grooming skills?

4	3	2	1
excellent	good	fair	poor

3. How would you rate the quality of service Mr. J has received from social services?

4	3	2	1
excellent	good	fair	poor

4. Have the service you received helped you to deal more effectively with your problems?

4	3	2	1
yes, they helped a great deal	yes, they helped somewhat	no, they really didn't help	no, they seem to make things worst

5. In an overall, general sense, how satisfied are you with the service you have received?

4	3	2	1
very satisfied dissatisfied	mostly satisfied	indifferent or mildly	quite

APPENDIX C

QUESTIONNAIRE FOR NURSING STAFF

1. How would you describe Mr. J personal grooming skills two weeks after admission?

4	3	2	1
excellent	good	fair	poor

2. Did Mr. J perform his personal hygiene skills without being advised?

4	3	2	1
never	sometimes	most	always

3. Did Mr. J personal hygiene skills improve during his hospitalization?

4	3	2	1
yes, a great deal	yes somewhat	no	seemed to get worst

4. How would you rate the quality of service the patient received from social services?

4	3	2	1
excellent	good	fair	poor

5. In an overall, general sense, did Mr. J's grooming skills improve?

1	2	3	4
no, definitely not	no, I don't think so	yes, I think so	yes definitely